(X3) DATE SURVEY

Division of Health Care Facilities

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** 01 - MAIN A. BUILDING B. WING _ TN4719 07/02/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6801 MIDDLEBROOK PIKE** WEST HILLS HEALTH AND REHAB KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 002: 1200-8-6 No Deficiencies N 002 During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6. Standards for Nursing Homes. Division of Health Care Facilities TITLE (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM If continuation sheet 1 of 1 6899 NCTH21

(X2) MULTIPLE CONSTRUCTION